THE RECOVERY KERNEL

COMPLEX TRAUMA AND THE SUBSTANCE CONNECTION

When the Drug Was Never the Real Problem

This chapter is for a specific and common situation the rest of the Recovery Kernel gestures toward but does not always name directly: substance use — especially benzodiazepines, alcohol, and opioids — that turns out, on closer examination, to be downstream of unresolved trauma from childhood. Being molested. Being beaten by a parent, with a belt, a wooden spoon, or a hand, in a way that crossed from discipline into abuse. Being abused by an older sibling — physically, sexually, or through sustained psychological cruelty — a category that is real and common and is very often not recognized as 'real' abuse because it happened at the hands of another child rather than an adult. Being raised in a home where humiliation, terror, or invalidation were the normal emotional weather. This chapter treats all of these as what they are: complex trauma, and it treats the substance use that so often grows out of them as exactly what Protocol 37 already says every substance is — a symptom report, not the disease itself.

⚠ CAUTION

This chapter discusses childhood abuse, including sexual abuse, at the level of mechanism and pattern — how it connects to later substance use — without graphic detail. If reading this brings up more than you expected, that reaction is common and it is not a malfunction; it is a sign that professional support, not this document, is the right next step. If you are in crisis right now: 988 (Suicide & Crisis Lifeline, call or text) is available 24/7. RAINN's National Sexual Assault Hotline is 1-800-656-4673. Both are confidential.

Section 1 — The Diagnostic Principle This Chapter Runs On

Protocol 37 (Substance Masking Analysis) states the Recovery Kernel's core diagnostic thesis directly: a substance is not simply a drug — it is an imperfect, costly solution to a genuine problem, and the specific substance a person gravitates toward is diagnostic information about what that problem is. The protocol's Masking Map is explicit about where benzodiazepines and alcohol fit into this.

Substance Class	What It Does	What It Is Masking (Per Protocol 37)
Benzodiazepines	Forced physiological calm	Panic, terror, inability to sleep — the always-on alarm state. Underlying: a dysregulated stress response axis, GABA receptor depletion, and trauma-induced hypervigilance that cannot deactivate.
Alcohol and depressants	Emotional numbing and lowered arousal	Anxiety, social friction, sensory overload. Underlying: chronic cortisol elevation and a dysregulated nervous system.
Opioids	Total sensory muting	Physical agony and existential despair. Underlying: unhealed structural injury or deep emotional trauma stored in the body as chronic pain.
Cannabis	Selective signal filtering	Hypervigilance, overload, the inability to filter what comes in. Underlying: anxiety-driven rumination loops that cycle without stopping.
Stimulants — cocaine, methamphetamine, amphetamines	Artificial energy — an overcurrent state	Exhaustion and the felt inadequacy of a depleted baseline. Underlying: adrenal fatigue, severe sleep debt, or a dopamine baseline deficit — and, in trauma-driven cases specifically, the chronic hypervigilant 'staying on' that a dangerous childhood made feel necessary for survival.
Kratom	Dual-mechanism: low-dose stimulant-like activation, high-dose opioid-like sensory muting	Depending on the dose profile, masks either the exhaustion of chronic hyperfunctioning (low dose) or the physical/emotional pain the opioid profile addresses (high dose) — see the Recovery Kernel Kratom Guide's three user profiles for the full breakdown.
Ketamine	Complete dissociation — disconnection from body, identity, and time	Intentional, deliberate escape from psychological pain, trauma, or a reality that feels unbearable. The Ketamine Guide names this directly: the dissociative state has a specific psychological function for many users, and it must be addressed directly for recovery to be durable. Underlying: unprocessed trauma the person is actively, if unconsciously, choosing to exit rather than experience.
GHB / GBL / 1,4-BD	Profound, rapid, near-total GABA-B sedation — a more complete 'off switch' than alcohol or	For some users, this masks ordinary anxiety or insomnia (see Section 3 below). For others, particularly where trauma and self-harm patterns coexist,

Substance Class	What It Does	What It Is Masking (Per Protocol 37)
	benzodiazepines provide	the pull toward GHB's totality of sedation can itself be an expression of wanting to disappear completely rather than simply calm down — a distinction worth naming honestly rather than softening, because it changes what recovery has to address.

Read plainly: if you were formed by an unpredictable or frightening childhood and you have found benzodiazepines uniquely, almost suspiciously effective — like they finally gave you the off switch nothing else ever did — Protocol 37 is telling you that is not a coincidence. It is your nervous system correctly identifying the one tool that reaches the specific alarm it has been running since before you had words for what triggered it.

⚠ CAUTION

A note on beer, wine, and the substances that don't look like a problem. Everything in the Masking Map above applies just as fully to the forms of alcohol that never get questioned — the nightly glass of wine, the beer after work, the drinking that stays inside socially sanctioned limits and therefore never has to justify itself. Two things make this category harder to see clearly rather than less real. First, heritability: alcohol use disorder has a substantial genetic component — family patterns of 'everyone in this family unwinds with a drink' are frequently not just a learned habit but an inherited biological vulnerability (the same GABRA2 architecture named throughout this chapter), meaning the trauma-masking function can be passed down the same line as the coping ritual that normalizes it. Second, social cover-up: families very often minimize, romanticize, or simply never name a parent's or grandparent's drinking — 'that's just how Dad unwound,' 'she needed her wine after a day with us' — which can obscure two things at once: whatever happened during those episodes, and the fact that the drinking itself was managing something. A substance doesn't have to look like a crisis to be doing exactly what Protocol 37 describes. It only has to be reliably reached for.

Section 2 — What Complex Trauma Actually Covers

Clinically, a single frightening event — a car accident, an assault by a stranger, a natural disaster — can produce PTSD. Complex PTSD is different: it comes from trauma that was repeated, prolonged, and interpersonal, especially when it occurred in childhood at the hands of the people a child depends on for safety. It adds a second layer on top of standard PTSD symptoms (intrusive memories, avoidance, hyperarousal): difficulty regulating emotion, a damaged and often permanently negative sense of self, and lasting difficulty in relationships — trusting people, feeling safe with intimacy, or knowing what a healthy relationship even looks like, because the template was never modeled safely.

Category	What It Includes	Why It's Often Missed or Minimized
Child sexual abuse (CSA)	Any sexual contact or exploitation of a child by an older person — family member, sibling, or someone outside the family.	Frequently concealed by the child at the time out of confusion, fear, or explicit threat, and often not disclosed to anyone — including a therapist — for decades, if ever.
Sibling-perpetrated abuse	Physical, sexual, or sustained psychological abuse by an older or more powerful sibling — a category with its own name in the trauma literature and its own recognition problem.	Commonly dismissed, including by the person it happened to, as 'just sibling stuff' or normal childhood conflict, because it happened inside the peer relationship rather than the caregiver relationship. The nervous system does not make that distinction. Repeated fear and powerlessness register as trauma regardless of the perpetrator's age.
Physical abuse	Being struck with an implement — a belt, a wooden spoon, an extension cord, or similar — with a severity, frequency, or intent that crosses from discipline into abuse; being struck with a hand in a way that produces injury or is driven by rage rather than correction.	Widely normalized across many cultures and generations as ordinary discipline, which can make it genuinely difficult for the person who experienced it to classify it as abuse at all, even when their nervous system's threat-response history says otherwise. Cultural normalization does not change what the body encoded.
Emotional and psychological abuse	Sustained humiliation, degradation, terror induction ('wait until your father gets home' as a chronic threat climate), invalidation of a child's reality or feelings, or being made to feel that love was conditional on performance or silence.	Leaves no physical mark and is the hardest category to point to as evidence, which often makes the person who experienced it doubt whether it 'counts' — while the nervous system responds to it with the same hypervigilance and dysregulation as the categories that do leave marks.
Abandonment disguised as	A parent with real financial means who outsources a child's actual	This is arguably the hardest category on this table to get

Category	What It Includes	Why It's Often Missed or Minimized
provision	care — a full-time nanny, a rotating string of babysitters, boarding school, being handed a credit card instead of attention — while remaining largely physically or emotionally absent. Material sufficiency substitutes for presence.	anyone, including the person it happened to, to take seriously — 'you had everything' functions as a real social argument against the abandonment having occurred at all. A child's attachment system does not register a nanny's presence as equivalent to a parent's, and does not register a credit card as equivalent to being seen. This category also frequently co-occurs with the others above: a household with enough resources to outsource care is also a household with enough privacy and social standing to keep other forms of harm from ever being questioned by anyone outside it.

BEING HEARD

If you read the physical abuse row and thought 'that was just how it was back then' or 'everyone got the belt' — that thought is common, and it is worth holding gently rather than accepting as the final word. Whether an implement, a frequency, or an intent crossed from discipline into abuse is not settled by how normal it felt at the time or how normal your family or culture considered it. It's settled by what it actually did to a developing nervous system that had no way to protect itself and no power to leave. And if you read the abandonment row and thought 'that's not real abuse, I had a nice house and never went without' — that's the exact dismissal the pattern depends on to stay invisible. Being materially provided for and being abandoned are not opposites. They can be, and often are, the same childhood.

Section 3 — The Substance-Trauma Co-Axis

The Recovery Kernel's substance guides each independently document the same pattern from a different angle. Pulled together, a picture emerges of which trauma category most commonly drives which substance preference — not as a rigid rule, but as a pattern reliable enough to be clinically useful.

Trauma Category	Commonly Masked By	Why
CSA / early sexualized trauma	Compulsive sexual behavior, opioids, or	Per the CSBD guide's Section 5: when sexual experience is

Trauma Category	Commonly Masked By	Why
	benzodiazepines	introduced in a traumatic context in early development, arousal and the trauma response can become neurologically fused, driving a compulsive attempt to re-process what was never processed. Opioids and benzodiazepines address the accompanying chronic pain and hypervigilance directly.
Sibling or parental physical abuse	Benzodiazepines, alcohol, or opioids	The chronic threat-state a child develops from unpredictable physical danger in their own home produces exactly the 'always-on alarm state' Protocol 37 names — the hypervigilance that never learned it was allowed to stand down.
Emotional abuse / chronic invalidation	Alcohol, cannabis, or stimulants	Chronic invalidation produces both the anxious rumination cannabis is reported to quiet and the depleted, 'never good enough' baseline stimulants are reported to temporarily correct.
Chronic hypervigilance channeled into forced achievement or 'staying on'	Methamphetamine or other stimulants	A common adaptation to an unpredictable or dangerous childhood is learning that constant productivity, alertness, or achievement was the only available form of safety or control. Stimulants directly supply the 'overcurrent state' Protocol 37 describes, and can feel less like getting high than like finally being able to keep up with a baseline the body has demanded of itself since childhood.
Trauma with a chronic pain or opioid-withdrawal component, or trauma-driven hyperfunctioning specifically	Kratom	Per the Kratom Guide's three documented user profiles, kratom's dual mechanism means it can mask either side of a trauma presentation: the opioid-like high-dose profile for physical pain or emotional numbing, or the stimulant-like low-dose profile for the same forced-productivity pattern methamphetamine masks — sometimes both, in the same person, at different doses.
Trauma the person is actively trying to escape from, moment to	Ketamine	The Ketamine Guide names this as a distinguishing feature of the substance itself: the dissociative

Trauma Category	Commonly Masked By	Why
moment, rather than manage in the background		state is often sought out deliberately, as an exit from a specific unbearable memory or reality, rather than as generalized anxiety relief. This is a meaningfully different pattern from the other rows in this table — closer to intentional escape than background self-medication — and recovery has to address the escape impulse directly, not just the substance.
Trauma co-existing with active self-harm patterns, where the goal is not calm but complete disappearance	GHB / GBL / 1,4-BD	GHB's capacity for near-total GABA-B sedation makes it capable of providing something qualitatively different from ordinary anxiety relief — a full, if temporary, exit from being present at all. When this specific pull is present, it is worth naming honestly as sitting closer to a self-harm pattern than a coping pattern, because the two require different, and differently urgent, responses. See the crisis resources at the start of this chapter and the immediate-safety guidance in the Recovery Kernel GHB Guide.
Attachment disruption from any of the above	Any substance, plus behavioral patterns (compulsive sex, workaholism, digital escape)	Per the CSBD guide: insecure attachment produces its own substance-independent behavior patterns — anxious attachment driving compulsive connection-seeking, avoidant attachment driving simulated intimacy without real vulnerability. The mechanism outlives whichever specific substance or behavior it attaches to.

THE CENTURION

This table is a diagnostic instrument, not a verdict. Not everyone who uses benzodiazepines has a trauma history, and not everyone with a trauma history develops a substance use disorder. But when the two are present together — and they are present together often enough that this chapter exists — treating only the substance while leaving the trauma unaddressed produces the predictable, well-documented result: the drug is removed, and the alarm it was silencing gets louder, not quieter.

Section 4 — Self-Abuse Through Social Media: The Digital Mask

There is a form of self-abuse that rarely gets named alongside substances, because it doesn't look like abuse from the outside — it looks like a habit everyone has. Compulsive social media use belongs in this chapter for the same reason benzodiazepines and alcohol do: it is not a separate problem sitting next to the trauma. It is frequently the trauma's most recent disguise.

What the Library Already Documents	How It Applies Here
Centurian Paper 14 (The Digital Detox / Co-Addiction Architecture): social media platforms are engineered to exploit the identical dopamine reward pathways as substances — variable-ratio reinforcement, the same schedule that makes slot machines addictive, applied deliberately to the feed.	The nervous system doesn't distinguish the delivery mechanism. A hypervigilant, trauma-shaped alarm system that once reached for a substance to quiet down will reach for a phone with the same urgency and the same relief-then-return cycle.
Protocol 35S.d.6 (Passive Consumption): 'the person who finds themselves unable to stop is not deficient in willpower. They are fighting an architecture specifically designed to override the willingness to stop.'	This is worth hearing directly if shame has already attached to the scrolling itself — per Protocol 35S.b (Section 5 above), this is a guilt-shaped problem (a behavior pattern) that has been miscategorized as a shame-shaped one (an identity flaw).
The Self-Help Trap (Centurian Paper 14): quitting a substance while consuming six hours a day of recovery or trauma content is named directly as 'addiction transfer to a more socially acceptable medium' — not recovery.	This is the exact mechanism in your question: watching content about trauma, healing, or recovery can feel like doing the work while actually functioning as the newest way to avoid doing it. The consumption substitutes for the confrontation.
The Withdrawal Doom Loop (Centurian Paper 14): a documented week-by-week pattern where a depleted post-cessation dopamine system reaches for scrolling to compensate, and the underlying condition never gets addressed because there was never any time carved out to address it — only time to consume more.	This is the mechanism behind 'no time to address the underlying cause.' It is not usually a literal scheduling problem. The hours exist — they are being spent. What's missing is the deliberate redirection of those same hours toward the trauma work in Section 7, rather than toward its digital anesthetic.

BEING HEARD

If any of this describes you, the reflex might be to feel a fresh wave of shame — one more thing to have failed at, on top of everything else this chapter has already named. That reflex is exactly the shame-versus-guilt confusion Protocol 35S.b is built to correct. You were not weak for finding relief in the one delivery mechanism specifically engineered by teams of specialists to be nearly impossible to resist. You found the same relief mechanism your nervous system was already looking for. That's not a

character defect. It's the alarm system doing what it has always done — finding whatever is closest and fastest.

A Self-Inventory: Is the Scrolling Masking Something?

Not a diagnostic score — a set of honest questions to sit with, the way Protocol 37 asks you to sit with what a substance was actually doing for you.

- Is your phone the first thing you reach for on waking, before you've had a chance to notice how you actually feel?
- Does scrolling ever function as the only reliable way to make an anxious, activated, or 'wired' feeling go quiet — the way Protocol 37 describes benzodiazepines doing?
- Have you used watching trauma, mental health, or recovery content as a stand-in for actually doing the work described in Section 7 — therapy, processing, disclosure?
- Do you lose track of time while scrolling in a way that resembles the dissociation or 'checking out' described elsewhere in this chapter?
- Is there a specific content category — doomscrolling news, comparison-heavy influencer content, true crime, content about people whose lives look like what happened to you — that you return to compulsively even though it reliably worsens your mood afterward?
- Have you chosen scrolling over calling someone, attending a meeting, or going to a therapy appointment because it felt easier in the moment?
- Does the idea of a real break from the app — not forever, just a week — produce anxiety that feels bigger than 'it's just an app'?

A handful of honest yeses here doesn't mean the phone is the problem any more than the benzodiazepine was the problem in Section 1. It means the same diagnostic principle applies: this is a symptom report. The Protocol 05 (Digital Detox) and Protocol 08 (Social Firewall) architecture in the main Compendium — environmental surgery, scheduled and bounded access, replacing rather than only removing — is the practical toolkit for the mechanism. It is not a substitute for Section 7. It's the same relationship Section 5 below describes between stabilization and processing: get the compulsive scrolling loop out of the way enough to have the attention available for the actual work underneath it.

Section 5 — Why Standard Recovery Work Can Miss This, and Sometimes Reopen It Wrong

Two timing errors are common enough to name directly, because both are avoidable with the right sequencing.

The Error	Why It Happens	The Correction

Starting trauma processing too early	In the urgency to 'get to the root cause,' trauma work sometimes begins before the person has enough biological and relational stability to tolerate it — before withdrawal has stabilized, before a support structure exists.	The Recovery Kernel's own opioid guide states this directly: trauma-specific work should not begin until the person is biologically stable and has a support structure in place. Beginning too early can destabilize and precipitate relapse. Stabilization first, processing second — not never, but not first either.
Generic moral-inventory work applied without trauma awareness	Standard recovery inventory work (examining 'my part' in past harm) is genuinely valuable for addiction-related harm the person caused. Applied without modification to what was done TO a person as a child, it can implicitly ask a trauma survivor to find their own culpability in their own victimization.	A child who was molested, beaten, or terrorized did nothing to cause it and has no 'part' to inventory in that specific harm. Any inventory or amends work should clearly separate 'harm I caused during my addiction' from 'harm that was done to me as a child,' and a trauma-informed guide or therapist should be the one navigating the second category — not a general inventory framework built for the first.

Section 6 — Full Protocol Cross-Reference

Reference	What It Offers Here
Protocol 37 — Substance Masking Analysis	The core diagnostic framework this entire chapter is built on: the substance as symptom report, not the disease itself.
Protocol 35S.b — The Weight of Shame	Directly relevant for abuse survivors, who very often carry shame that was never theirs to carry. Distinguishes guilt ('I did something wrong' — behavior, addressable) from shame ('I am something wrong' — identity, totalizing) and offers Strategic Selective Disclosure as the mechanism for breaking shame's isolation logic: at least one person with full knowledge of the history who stays.
Protocol 33 — The Boundary Architect	For the common situation where the person who caused the harm — a parent, an older sibling — is still a living presence in your life. Offers a framework for sharing recovery space without imposing it and setting boundaries without requiring the relationship to end or forcing a confrontation

Reference	What It Offers Here
	before you're ready for one.
Protocol 34 — Cognitive Stabilization	Names intrusive thoughts and flashbacks as neurological artifacts of a dysregulated system, not moral events or signs of instability — relevant for the intrusive memory component of complex PTSD specifically.
Protocol 05 (Digital Detox) and Protocol 08 (Social Firewall)	The practical toolkit for the digital masking pattern in Section 4: environmental surgery, scheduled and bounded access, and replacement rather than only removal.
Centurian Paper 14 — The Digital Detox / Co-Addiction Architecture	The full documentation of social media's shared reward-pathway architecture with substances, the Self-Help Trap, and the Withdrawal Doom Loop referenced in Section 4.
Protocol 35S.d.6 — Passive Consumption	The clinical framing of compulsive scrolling as engineered architecture rather than a willpower failure, referenced directly in Section 4.
GABA Braking Systems, Chapter 10	The biological mechanism underneath the benzodiazepine-hypervigilance connection named in Protocol 37 — GABRA2 and GABRB3 status shape how much inhibitory 'brake' was available to begin with, which is part of why the same childhood environment produces different degrees of substance vulnerability in different people.
Protocol 16 / C-25 — The Isolation Spiral	Trauma, and the shame that often accompanies it, drives withdrawal from exactly the connection that recovery depends on. Relevant to both the abuse history and the substance recovery running alongside it.
Protocol 20, Protocol 21, C-28 — Identity Architecture	For rebuilding identity as a person whose history includes both the abuse and the addiction it fed, without either one becoming the entire story — 'the addiction is one folder in the whole, not the root directory.'
Recovery Kernel CSBD Guide, Section 5	If compulsive sexual behavior is present alongside or instead of substance use — a well-documented comorbidity specifically with CSA — this section maps the trauma-to-behavior mechanism in full.
Recovery Kernel Kratom Guide, Section 1.3	The three documented kratom user profiles (opioid replacement, chronic pain management, energy/focus) referenced in Section 1 and Section 3 above — useful for identifying which side of kratom's dual mechanism is doing the masking.
Recovery Kernel Meth/Stimulant Guide	For the forced-achievement, chronic-hypervigilance pattern named in Section 3 above — the guide's recovery architecture addresses the dopamine baseline directly, alongside the trauma work this chapter points toward.
Recovery Kernel Ketamine Guide, Section 6 (Grounding Architecture)	For the intentional-dissociation-as-escape pattern named in Sections 1 and 3 above — the guide's own language names ketamine as escape 'from psychological pain, trauma, or a reality that feels unbearable,' and its grounding architecture is built specifically for this.
Recovery Kernel GHB Guide, Section 0	Read this immediately if the GHB pattern in Sections 1 and 3 above applies. GHB withdrawal at high-frequency use is a documented medical emergency independent of the trauma

Reference	What It Offers Here
	work this chapter addresses — the physical safety guidance takes priority.

Section 7 — This Extends Into Needing Psychotherapy

Everything in this chapter, and everything cross-referenced above, is scaffolding: education, a diagnostic frame, biological context, and language for a pattern that may not have had language before now. None of it is trauma treatment. Complex trauma from childhood abuse — sexual, physical, or emotional — is not something a supplement stack, a breathing protocol, or a well-written chapter resolves. It requires trauma-specific psychotherapy, and that is not a caveat tacked onto the end of this chapter — it is the actual next step the rest of this chapter has been pointing toward.

THIS NEEDS A THERAPIST

The modalities with the strongest evidence specifically for trauma, as distinct from general talk therapy, are: EMDR (Eye Movement Desensitization and Reprocessing), CPT (Cognitive Processing Therapy), Prolonged Exposure, Somatic Experiencing or Sensorimotor Psychotherapy for trauma stored in the body, and IFS (Internal Family Systems) — widely used specifically for complex, developmental trauma because of how it works with the different 'parts' a person develops to survive a chronically unsafe childhood. A general therapist without specific trauma training may be a good fit for many things, but this work benefits from someone credentialed and experienced specifically in trauma treatment — it is reasonable and expected to ask a prospective therapist directly what modality they use for complex trauma and how much of their practice is trauma-focused.

Sequencing matters, and it is not a sign of avoidance to go slowly. Per Section 5 above, stabilization — medical, if a substance is still involved; relational, in terms of basic support; and physiological, in terms of the buffering this library provides — generally comes before the deepest trauma processing work, not instead of it. A trauma-informed therapist will typically assess for this sequencing directly rather than diving straight into processing on the first session.

When Professional Therapy Isn't Available Where You Are

Everything above assumes access to a trauma-trained therapist is possible. For many people reading this, it isn't — not because the need isn't real, but because of geography, cost, or a home country where the politics or the religious climate make trauma disclosure, including disclosure of abuse by a family member, genuinely dangerous to pursue openly. This gap is real and worth addressing directly rather than leaving the chapter's advice unreachable for the people who may need it most.

⚠ CAUTION

Online and telehealth therapy is increasingly available across borders and can be a safe, legitimate way to reach a trauma-trained therapist when nothing suitable exists locally. But it is not automatically legal or safe everywhere, and this is exactly the kind of thing worth checking before starting, not after — cross-border telehealth, data privacy protections, and even the act of discussing certain topics (abuse, family conflict, or content that touches on politically or religiously sensitive ground) can carry real legal risk in some jurisdictions, independent of how the therapy itself goes. Verify local legality and any relevant risk directly — through a local lawyer, a trusted local resource, or, per the Recovery Kernel's Global Legal Realities series, jurisdiction-specific guidance where it exists — before assuming a platform based in another country is automatically a safe option.

Where professional therapy is genuinely out of reach — financially, geographically, or because it isn't safe to pursue openly — books are a legitimate and powerful form of self-directed work, not a consolation prize. This is sometimes called bibliotherapy, and it has real evidence behind it specifically for trauma processing. It will not replace what a skilled trauma therapist offers, particularly for the deepest processing work, but it can be a genuine way to self-author — to build the language, the framework, and the sense of not being alone in this that often has to come before any other kind of healing can start. Widely regarded starting points specifically for complex trauma include Bessel van der Kolk's The Body Keeps the Score, Pete Walker's Complex PTSD: From Surviving to Thriving, and Lindsay Gibson's Adult Children of Emotionally Immature Parents — though availability, translation, and even legality of specific titles varies by country, and that too is worth checking locally rather than assumed.

□ SANCTUARY

If therapy isn't reachable right now, that does not mean the work described in this chapter is out of reach — it means the starting point looks different. A book read alone in a country where this conversation has to stay private is still you doing the work. It still counts.

□ SANCTUARY

None of what happened to you was your fault, whatever form it took and whoever caused it. The substance, if there was one, was never the real problem — it was your nervous system's best available answer to a problem that started long before the substance did. Naming that clearly, the way Protocol 37 asks you to, is not the end of the work. It's the correct starting point for work that a good trauma therapist can actually finish with you.

END OF CHAPTER — COMPLEX TRAUMA AND THE SUBSTANCE CONNECTION

Educational Resource — Not a Substitute for Trauma-Specific Psychotherapy

Crisis Resources: 988 (Suicide & Crisis Lifeline, call or text) | RAINN National Sexual Assault Hotline: 1-800-656-4673 | Crisis Text: HOME to 741741